

PATIENT MEDICATION AND ALLERGY LIST

Patient name: _____

DOB: _____

Please list the medications you are taking, including over-the-counter medications & herbal supplements.

Name of Medication	Dosage / Strength	Time Taken	Reason for Taking

(Please use the back side of this form if you need more space for requested information.)

Please list all known allergies and reactions including medications, food, or other:

Allergy

Reaction

Name of pharmacy you use: _____

Phone #: _____

Name of Primary Care Physician: _____

Phone #: _____

Patient signature: _____

Date: _____

Signature if other than patient: _____

Date: _____

Relationship to patient: _____

